Cancer Genetics Network Interview

University of Pennsylvania
Cancer Genetics Network

Name_____
DOB_____

Is any other member of your family
Enrolled in the Cancer Genetics Network?

[ ] Yes [ ] No [ ] Unknown

If yes, Name(s)
_____ DOB _____
_____ DOB _____

Completed by (circle one and fill in)
Self Other_____
(Relationship)

Today's Date: _____/_____/_____
MM DD YYYY

For office use only.

Center #: _____

Subcenter #: _____

Patient Clinic Record#:_____
Originating Clinic:_____

Interviewer:_____

CGN Full Partic.: Y N

Ascertainment Mode:

- ❑ **Population Based**
- ❑ **Clinic**
- ❑ **Referral**

Data Quality Code: 1 2

Referral Source (check one):

___ Self
___ Advertisement
___ Friend/family
___ Health fair
___ Relative of cancer patient
___ University information line
___ In-house provider
___ External provider
___ Regional cancer information source
___ Tumor registry (local/state)
___ Hospital registry
___ Genetics counselor or clinic
___ Web site
___ Purchased list
___ Other research study
___ Other

Background Information

Gender M____ F____

What is your date of birth?

_____/_____/_____
MM DD YYYY

Your ethnic/racial background:
(Check all that apply)

Self	Biological Mother	Biological Father	
____	____	____	White/Caucasian
____	____	____	Black or African-American
____	____	____	Native American/Aleutian/Eskimo
____	____	____	Asian: *Specify Below*
____	____	____	Pacific Islander, Not Otherwise Specified
____	____	____	Hawaiian
____	____	____	Other: *Specify Below*

Self: _____

Mother: _____

Father: _____

Spanish or Hispanic origin or descent:
(Check all that apply)

Self	Biological Mother	Biological Father	
____	____	____	Non-Spanish, Non-Hispanic*
____	____	____	Mexican, including Chicano, Not Otherwise Specified
____	____	____	Puerto Rican
____	____	____	Cuban
____	____	____	South or Central American (except Brazilian, *See note below*)
____	____	____	Other specified Spanish origin (includes European)
____	____	____	Spanish, Hispanic, or Latino, Not Otherwise Specified
____	____	____	Spanish surname only
____	____	____	Unknown

**Note: Brazilian and Portuguese considered Non-Spanish, Non-Hispanic*

Are you of Ashkenazi (Eastern European) Jewish descent? (circle one)

Yes No Unknown

What best describes your religious heritage or affiliation? (Please give only one response)

_____Protestant/Other Christian
_____LDS/Mormon
_____7th Day Adventist
_____Jehovah's Witness
_____Catholic
_____Jewish
_____Moslem
_____Hindu
_____Buddhist
_____Other *Specify Below*
_____Agnostic\ Atheist\ None
_____Unknown

If other, please specify: _____

What is the highest level of schooling you have completed?

____8 years or less
____Some high school
____High school grad/GED
____Some college or technical school
____Graduated college or beyond
____Unknown

What is your current marital status?

____Never married
____Married or living as married
____Separated
____Divorced
____Widowed
____Unknown

General Medical History

All:

Have you ever been diagnosed with cancer of any kind?

Y N Unk

If yes, what type(s) and at what age(s)?

Cancer Type	Age Diagnosed
_____	_____
_____	_____
_____	_____

Has a doctor ever told you that you had any of the following conditions: (Circle Y or N and list age at diagnosis.)

		Age Diagnosed
Non-cancerous lumps or cysts in the breasts or fibrocystic breast disease	Y N Unk	_____
Colon polyps	Y N Unk	_____
Familial polyposis (Colon is covered with hundreds of polyps; runs in families)	Y N Unk	_____
Ulcerative colitis	Y N Unk	_____
Any major birth defects, genetic disorders or inherited conditions	Y N Unk	

If Yes: Specify type(s):

_____

		Age Diagnosed
Women only:		
Benign ovarian tumors or cysts	Y N Unk	_____
If yes, polycystic ovaries?	Y N Unk	_____
Men only:		
Enlargement of the prostate	Y N Unk	_____

All:

Have you ever had any of the following surgeries for any reason? If so, please indicate at what age.

Procedure		Age Performed
Removal of colon (Colectomy)	Y N Unk	_____
If Yes, check	Partial Complete Unknown	
Removal of breast(s) (Mastectomy)	Y N Unk	

*If Yes, please indicate **age(s)** for*:

One side_____ Both simultaneously_____

Opposite side_____ (2^{nd} surgery) Surgery Type Unk_____

Thyroidectomy Y N Unk_____

Women only:		Age
Removal of uterus (Hysterectomy)	Y N Unk	_____
Removal of ovaries (Oophorectomy)	Y N Unk	_____

*If Yes, please indicate **age(s)** for*:

One side_____ Both simultaneously_____

Opposite side_____ (2^{nd} surgery) Surgery Type Unk_____

Men only:		Age
Removal of the prostate (Prostatectomy)	Y N Unk	_____
Trans Urethral Resection of the Prostate	Y N Unk	_____

Family History

Are you adopted? Y N Unknown

Are you a twin? Y N

If Yes: ___Identical ___Fraternal ___Same sex, unknown if identical ___Unknown

Total number of living and deceased (biological):
Check box if unknown.

☐ _____Full brothers ☐ _____Full sisters
☐ _____Half brothers ☐ _____Half sisters
☐ _____Sons ☐ _____Daughters

Total number of living or deceased aunts/uncles:
Check box if unknown.

	On Your Father's side	**On Your Mother's side**
	☐	☐
Your Uncles:	_____	_____
	☐	☐
Your Aunts:	_____	_____

Please complete the following tables for **blood relatives**, both with and without cancer, whether **alive or deceased**.

Relative	Year of Birth	Cancer Type(s)	Age(s) @ Diagnosis	Age @ Death
Spouse				
Son #1				
Son #2				
Son #3				
Son #4				
Son #5				
Daughter #1				
Daughter #2				
Daughter #3				
Daughter #4				
Daughter #5				

Relative	Year of Birth	Cancer Type(s)	Age(s) @ Diagnosis	Age @ Death
Father				
Mother				
Brother #1 __Full __Half (same mother) __Half (same father)				
Brother #2 __Full __Half (same mother) __Half (same father)				
Brother #3 __Full __Half (same mother) __Half (same father)				
Brother #4 __Full __Half (same mother) __Half (same father)				
Brother #5 __Full __Half (same mother) __Half (same father)				
Sister #1 __Full __Half (same mother) __Half (same father)				
Sister #2 __Full __Half (same mother) __Half (same father)				
Sister #3 __Full __Half (same mother) __Half (same father)				
Sister #4 __Full __Half (same mother) __Half (same father)				
Sister #5 __Full __Half (same mother) __Half (same father)				

Your Father's Side: Complete for both grandparents, and for other relatives ONLY if they had cancer				
Relative	**Year of Birth**	**Cancer Type(s)**	**Age(s) @ Diagnosis**	**Age @ Death**
Grandfather				
Grandmother				
Uncle #1 (only if had cancer)				
Uncle #2 (only if had cancer)				
Uncle #3 (only if had cancer)				
Aunt #1 (only if had cancer)				
Aunt #2 (only if had cancer)				
Aunt #3 (only if had cancer)				
Other Relative_____ M F Unk				
Other Relative_____ M F Unk				

Your Mother's Side: Complete for both grandparents, and for other relatives ONLY if they had cancer				
Relative	**Year of Birth**	**Cancer Type(s)**	**Age(s) @ Diagnosis**	**Age @ Death**
Grandfather				
Grandmother				
Uncle #1 (only if had cancer)				
Uncle #2 (only if had cancer)				
Uncle #3 (only if had cancer)				
Aunt #1 (only if had cancer)				
Aunt #2 (only if had cancer)				
Aunt #3 (only if had cancer)				
Other Relative_____ M F Unk				
Other Relative_____ M F Unk				

Tobacco History/Contact Information

Tobacco History

Have you ever smoked at least 100 cigarettes (5 packs) in your lifetime?

_____No

_____Yes, and currently smoke
Age start_____

_____Yes, and no longer smoke
Age start_____ Age stop_____

_____Years total (Minus periods of non-smoking)

Number of cigarettes smoked daily (avg)_____
[*Note: 1 pack=20 cigarettes*]

Other regular tobacco use (once per week or more):

Never	Current	Former	
____	____	____	Pipe
____	____	____	Cigars
____	____	____	Chewing or smokeless tobacco

Genetic Risk Assessment

Have you participated in genetic counseling or genetic testing to evaluate your possible familial cancer risk?

Genetic counseling Y____ N____ Unknown____
Genetic testing Y____ N____ Unknown____

Would you be interested in further information about hereditary cancer risks?

Y____ N____ Don't know____

Contact Information

Name:_____

Please verify your address, phone# and e-mail:

_____

_____

_____

_____

Phone: day:(____)_____-_____
eve:(____)_____-_____

E-mail: _____

Which is your preference for future contact:

Mail_____ Telephone_____ E-mail_____

Best time to contact you: _____

Is there a family member who we might contact in case we lose touch with you?
Other Contact Information:

_____

_____

_____